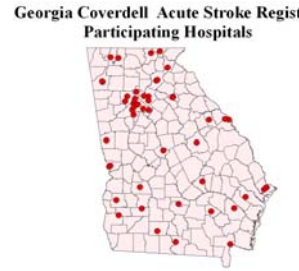
Georgia Coverdell Acute Stroke Registry Quarterly Newsletter



FALL 2011

Coverdell Partners:

Georgia Division of Public Health (DPH)

Emory University School of Medicine

Georgia Medical Care Foundation (GMCF)

American Stroke Association (ASA)

Georgia Hospital Association (GHA)

If you have anything you would like included in an upcoming newsletter or have achieved recent recognition in the area of stroke, contact:

Kerrie Krompf
kkrompf@emory.edu
or
404-616-8741

"What's Up With Stroke in Georgia?"

I recently spoke at the Georgia Organization of Nurse Leaders (GONL), providing a history and current overview of Stroke Care in Georgia. Kerrie Krompf asked if I could put it into an article for the Coverdell Newsletter. I thought that was a great idea, but then started thinking. What does it say about my age when I'm asked to write a historical article . . . and I remember when it all happened? Let's drop that depressing train of thought! When I first became a nurse (in the dark ages), the only treatment available for stroke was supportive care. The length of hospital stay could be 20-30 days and patients would be discharged directly to the care of their very frightened family. Then in 1996, the FDA approved Activase for the treatment of acute ischemic stroke with symptom onset of 3 hours or less. This was a real game-changer for stroke, but physicians and hospitals were slow to adopt this treatment.

Beginning in 2000, stroke care finally began to build momentum. Sadly, Georgia Senator Paul Coverdell died of a massive stroke in 2000. This brought national attention to the death and disability caused by stroke. As a result, the "Coverdell Registry" was conceived. After partnering with the American Stroke Association's "Get With The Guidelines" GWTG-S program, Coverdell piloted data abstraction from 2001 – 2003. It began with four states, Georgia, Illinois, Massachusetts, and North Carolina, and subsequently has spread to several additional states. Georgia's Registry began with 26 hospitals in 2005 and now proudly boasts 60-plus participating hospitals. The objectives of Coverdell & GWTG-S included promotion of :

- Dynamic, evidence-based guidelines
- Use of standardized order sets
- Primary and secondary prevention
- Ongoing research into the care and prevention of stroke

The next milestone came in 2008 with introduction of the "Harmonized Measures" for stroke. Wonder of all wonders, three leading agencies (American Heart Association, the Centers for Disease Control and Prevention, and The Joint Commission) agreed on specific wording and criteria for 10 standardized stroke performance measures. At long last, everyone was singing from the same page, which was a tremendous relief for harried Stroke Coordinators trying to chase conflicting guidelines from different agencies. Since that time two of the measures (Dysphagia Screening and Smoking Cessation) have been temporarily suspended by The Joint Commission (TJC).

The GWTG-S database has become a robust and comprehensive source of information and learning. As of today, there are 2,039 hospitals participating in the database and more than 1.8 million patient records entered. There are more than 30 hospitals in Georgia certified as Primary Stroke Centers. Although it's difficult to get an exact count, there are about 10 hospitals in Georgia performing interventional procedures for stroke. We continue to evolve and advance with passage of the Coverdell-Murphy Act, which established a two-tier system of stroke with the designation of Primary Stroke Centers and Remote Treatment Centers. This is encouraging development and enhancement of "Stroke Systems of Care."

Any discussion of stroke in Georgia must include mention of the "Georgia Stroke Professional Alliance" (GA-SPA). This began as an informal group of just seven stroke coordinators meeting in Atlanta for dinner. In just four short years, this has grown to a membership of over 200 professionals throughout the state, boasting a true collaborative philosophy. GA-SPA holds quarterly meetings, rotating sites throughout the state. Members who are unable to attend may participate through teleconference. Officers are elected by the members. The group hosts a website and in 2012 will seek designation as an official non-profit agency.

What's in our future? Georgia is poised to make tremendous advances in the care and outcomes of stroke. We expect to see considerable growth in telemedicine and telestroke. There will be continued refinement of the network of stroke hospitals as the Coverdell-Murphy Act evolves. There are only a handful of stroke-ready hospitals in South Georgia and we are all keeping our fingers crossed for state attention to help our southern cousins enhance availability of stroke care. The Joint Commission is currently working on standards to recognize "Comprehensive Stroke Centers," which will be launched in late 2012. This will probably lead to a true three-tier system: Comprehensive Stroke Centers, Primary Stroke Centers, and Stroke Capable Hospitals.
Since I don't really have a crystal ball, I'm sure there are other advances that I haven't even imagined. One thing is for sure – in Georgia, stroke is on the move. Welcome aboard!

Submitted by Trish Westbrook, RN, MSN, FNP-C, Stroke Coordinator, Northeast Georgia Medical Center

Habersham Medical Center
Stroke Awareness Education Success Story

Lucille Helton, a longtime volunteer at Habersham Medical Center in Demorest, spends many hours assisting inpatients and visiting with the residents of the medical center's long-term care facility. She always has a warm, friendly smile and loves to dress up in her favorite costumes to make others smile as well.

While eating lunch in the medical center's cafeteria during the month of May, National Stroke Awareness Month, she casually read or glanced over the tent cards placed on the Tables educating employees, volunteers and the public of the warning signs of stroke.

A few weeks later, her husband, Dean, turned to his wife of 48 years, and said "Lu something is wrong." She quickly noticed his mouth was drawn, his speech was slurred and he couldn't raise his right arm and recognized he was having a stroke. She remembered the stroke educational materials she had read and sought medical attention.

"Thankfully, Dean is improving," says Lucille. "He is on the road to recovery. I'm blessed to work with great people at Habersham Medical Center and am thankful we have a wonderful stroke program and are a Certified Primary Stroke Center. I often read about our stroke program in the local newspaper and am thankful Habersham Medical Center took such excellent care of my husband."

For Habersham Medical Center Volunteer Lucille Helton, strokes are no laughing matter. While volunteering at the Medical Center, she read about the warning signs of a stroke and helped save her husband's life.

Submitted by Teri Newsome, VP of Quality, Habersham Medical Center

Coverdell Welcomes New QI Director

We'd like to take this opportunity to welcome our new QI Director, James Lugtu. James has been a Registered Nurse since 2005. He graduated with a BSN from Jacksonville State University and is currently pursuing his goal to become a Nurse Practitioner at Troy University. For the last seven years James has worked with various aspects of Neuroscience nursing and program development. He served as the Stroke Program Coordinator and Manager of the Brain and Spine Center at The Medical Center in Columbus, Georgia. James has successfully headed The Medical Center's stroke program through two Joint Commission Primary Stroke Center surveys both resulting with no recommendations for improvement. His focus area and passion is acute stroke care. His desires to improve stroke care beyond the confines of one hospital led him to accept his current position as QI Director for the Georgia Coverdell Acute Stroke Registry.

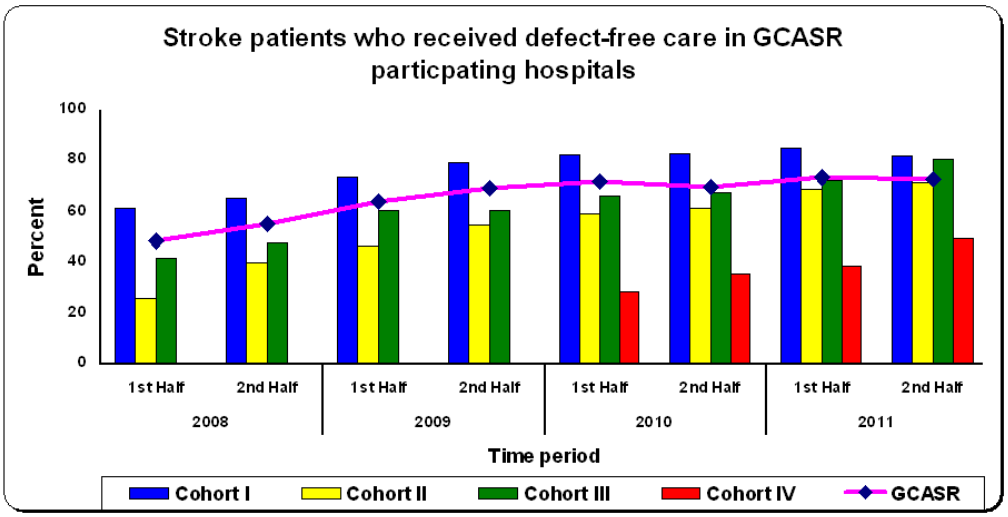
Defect-free Care: The Sensible Indicator of Process Change in Acute Stroke Patient Care

A multifaceted approach is necessary to obtain optimum results in stroke patient management. The Centers for Disease Control and Prevention, in collaboration with its partners, has identified ten specific interventions that have been shown to improve the outcome of stroke patient care: venous thromboembolism prophylaxis, anticoagulation for patients with atrial fibrillation, anti-thrombotic for ischemic stroke patients within 48 hrs of admission and at discharge, thrombolytic therapy within 3 hours of last known well for eligible patients, lipid therapy, dysphagia screening, smoking cessation counseling/treatment, stroke education, and rehabilitation plan.

Although each of these interventions has benefits on its own, their combined effect is believed to be more pronounced than their summation. On the other hand, the lack of one required intervention is more likely to reduce the net effect of other treatment measures. Thus, quality improvement initiatives in stroke patient care have taken a comprehensive approach, striving to adhere to the clinical guidelines and provide all the recommended interventions to patients who need them.

Defect-free care (DFC) is an accepted method for conservatively defining optimal quality care using multiple indicators for the ten interventions. It is defined at the patient level as 100% adherence to all of the indicators for which the patient is eligible. It is not sensitive to small positive changes made in one aspect of patient care. Any increase in DFC indicates improvement in the overall stroke patient management, which happens when there is a concerted effort by clinical care providers and supporting staff, and when facilities put an appropriate system in place to treat stroke patients. Gains in defect-free care can be lost quickly if there is no consistency in adherence to the treatment guidelines.

The Georgia Coverdell Stroke Registry (GCASR) has recruited acute care hospitals at four different times, with a fifth currently underway. Each cohort has shown a consistent improvement in defect-free care over time (See graph below). Although information on quality improvement in stroke patient care was available from various sources, each subsequent cohort started at a lower rate of DFC than the GCASR average. Currently, information is not available to compare total DFC performance of GCASR-participating with non-participating hospitals; however, the two points mentioned above strongly indicate that participation in a statewide registry program does in fact help to improve the quality of stroke patient care.



Supporting Change in Stroke Clinical Practice

There is one thing for certain in stroke care and that is that change is constant. I think we all have encountered the frustration of our staff when we are asking them to change a process one more time in the care of stroke patients or to learn yet another skill in order to meet the evidence-based guidelines.
I would like to share with you some of the strategies I have employed to make change, if not less painful, perhaps even a bit of fun!

Tap into your nurses' competitive spirit! Many nurses are no different than anyone else and enjoy a little healthy competition both amongst themselves and with nursing groups outside their organization. One thing I started doing to help improve the door-to-needle (DTN) times in our ED is to post the stroke alert key times along with the nurse caring for the patient on one of the ED staff bulletin board so they can see who has been achieving times under 60 minutes and who has the shortest times. I have had staff approach me with stories about how quickly they were able to initiate tPA for a particular patient. I got some great strategies from those conversations for improving our DTN times. For example, we had a very difficult case 2 weeks ago which I had been able to be a part of. Afterward the nurse caring for the patient remarked how quickly we initiated tPA (37 minutes!) and transported the patient by air for intervention in less than 60 minutes with tPA infusing. I asked her what she thought was the key to exceeding our goal so dramatically. She said that she decided to handle the patient like a trauma case. She never left the patient and had other staff get her what she needed and bring it to her. That way she felt she was more in control of what was happening and how quickly it happened. This strategy will be discussed at our next ED charge nurse meeting to consider making it a standard part of our process.

Another way to support change or meet goals for your stroke program is to use some friendly competition to benchmark with other hospitals. I report the quarterly data from Outcome Sciences Stroke On Demand Trend Reports and Slides at our monthly Stroke Advisory meeting. The representatives from the clinical areas then takes these reports and share them with their staff to let them know how we are doing compared to other Stroke Centers both at the state and national level. All too often we are in the position to be looking at our own numbers which may not always be where you want them to be. Sometimes when they see with just a little more effort they can move ahead of other hospitals, they give the added effort and become more aware of the challenges. The slides really paint a graphic image to see where they stand when compared with other stroke centers. The other bonus to this is that they also get to see where they outshine other facilities and this helps to reinforce their efforts and continue to work to keep up the gains they have made.

Competition aside there is no better motivator than a little old fashioned incentive program! We have given gift cards (our marketing department helped us with these) to all nurses for DTN times under 60 minutes one month, and then the next month we gave one larger gift card to the nurse with the shortest DTN time. We made posters of each nurse with their key times in achieving their DTN time and included a picture of her/him entitled "Brain Saver" and gave them a certificate of achievement with other staff present, which made it fun and helped the other staff to think about what they might do to get a reward. I currently have an incentive program going for ED staff to get certified in the NIHSS for both RN's and MD's. They have to get certified and turn in a copy of their certification to me and then they have to produce a copy of a completed NIHSS on a stroke alert patient and I have to verify documentation in the chart. When I receive and verify this, I take the ED Director, the ED QI nurse, and if I can get our Medical Director or VP of Nursing to join in, we go as a group to present them with their prize. I write a hand written thank you note to acknowledge their effort and contribution to improving patient care and read it out loud when their gift is presented. That competition is ongoing but we had over 25 ED staff sign up to get certified—so we have fostered voluntary change in a positive way.

I hope these ideas get your creativity flowing and encourage you to look at how you can make some of the work and change we do on behalf of patients with stroke fun for your staff. It doesn't have to be a big prize, it can be something as little as a printed certificate or a lunch voucher in the cafeteria. If you have any ideas you want to share please send them out to our Coverdell hospitals and we then can reproduce these ideas to foster change or reinforce a process – all in a day's work in treating or preventing stroke!

Submitted by Kim Anda, RN, Manager of Stroke Services, Southern Regional Medical Center

Wellstar Kennestone's Stroke Event
"The Price Is Right"

In an effort to provide staff with stroke education that is not only informative but also fun, our ICU stroke champion turned an idea into a paragon of what can be done with some imagination and help from friends. Katrina Joyce, RN, the creative mind behind "*The Price Is Right*" event, used a game show as a venue to provide stroke education. The plan was to recreate the original game and replace all the pricing questions with questions about Stroke. This educational opportunity was open to all WellStar employees and all departments were encouraged to attend. One did not need to be a health professional to play the game.

After several planning meetings it was determined what games we could build, along with the questions for the individual games. Some games required multiple choice answers; some needed an answer that was either a number or a percent, while a different game required True/False questions. After delegating the work assignments we were off, and over the next two months, under the watchful eye of Katrina, "The Price is Right" for Stroke Education was created.

The games chosen were: PLINKO, Mountain Man, cups, the card game, mini golf, & roll the dice. These games were designed on a grand scale in order to provide the best experience for our contestants and audience members. The show was held in an auditorium capable of holding about 150 people.

The games were transported to the Auditorium two weeks prior to the event. We had one rehearsal with the games to work on timing. Our goal was to keep the flow very close to its original format as we knew some staff would be using this hour as their lunch break. After the rehearsal we had some items to work on and each person left with a punch list once again. This is where the dedication of all involved brightly shined. Everyone on the set was willing to do whatever it took to make this a success. I wonder if this is how it really is in "show biz"? Adam worked diligently on the acoustics and the timing of the music and the sounds for each game. Susan, Lalie, and Janie attended to the details of the games to get exact positioning for the best contestant and audience experience. All the fine points of the game were under the cogent direction of Katrina.

Game day… Katrina was nervous, not only because we had a scant 32 RSVP's, but also because The Joint Commission stepped onto our campus on Monday for our 5-day hospital survey. But the show must go on, and so it did. The opening "Price is Right" music was playing, the decorations were up, the games were set, and the contestants started pouring in. By the beginning of the show we estimated having over 100 audience members. It was amazing to see contestants have their name called and see them running and shouting down the aisle like they were going to win a million dollars! The audience was encouraged to help answer the questions and as the contestant progressed through the games, the level of audience participation grew. In the final round contestants played for a 2-night, 3-day stay at a beach resort in Florida. Our winner was an enthusiastic nurse from Cobb Hospital. The event generated great reviews and The Joint Commission who also attended this event buzzed about it for two days. Overall, this was a great success and future plans are to make it an annual event.

Our team was fortunate to receive an anonymous monetary donation to help fund the prizes, for which we're truly grateful.

Examples of the questions we used for the specific games.

Round one:

- Women account for _____% of all strokes
- How many patients are admitted to Wellstar with symptoms of a stroke from Jan. 2011 to June 2011?
- What percentage of Georgians is considered obese and overweight?

Round two:

- What is the average length of hospital stay for a stroke patient?
- How much does tPA cost?
- What percent of patients have a second stroke within a year of their first one?

Game Questions:

- What is the average age of a stroke patient?
- Healthy adults should perform moderate physical activity for at least _____min for 5 or more days a week. (15, 30, 45)
- List 5 Modifiable Risk Factors. Answer: Smoking, obesity, high blood pressure, etc.
- Sudden trouble seeing in one or both eyes is a symptom of having a stroke? (T/F)
- Which is <u>not</u> a S&S of a Stroke? Numbness/tingling on one side of the body, back

pain, slurred speech, or facial drooping
- Within 5 years of quitting smoking your risk factor is the same as someone who has never stopped? (T/F)
- Stroke occurs every _____ seconds.
- Females are more likely to have a stroke than males? (T/F)
- HTN is the primary cause of hemorrhagic strokes? (T/F)
- How long can the brain go without O2? (6 minutes)
- Hypertension is a systolic (top number) blood pressure greater than __.
- What percentage of people will end up in a nursing home permanently disabled?

Our team consisted of Bob Barker played by one of our Neuro Surgeons Dr. Hill, Rod Roddy the announcer was played by our EMS Liaison Adam Bomar, and three support people who assisted with the flow of the game. Lalie Mode, ICU RN, changed the games in between sets, Susan Zimmermann, Stroke Coordinator held the "applause" signs and Courtney Sarno ICU educator eloquently showcased the prizes. I would be remiss if I did not mention the husbands who helped create and transport the games as well as Janie McKinley and Carrie Deloughy, who assisted with the intricate details of the games. Our valiant director Katrina Joyce stuck to the plan and fastidiously kept us all on track.

It only takes one imaginative mind with a great support team to pull off an incredible Stroke Awareness journey.

Submitted by Susan Zimmermann, Stroke Coordinator, Wellstar-Kennestone

Redmond Regional Medical Center (RRMC)

Redmond Regional Medical Center has had a busy few months! For starters, we transitioned to a new Stroke Coordinator on June 20, 2011. Redmond welcomed Misty Burkhalter, RN, to that position. Misty took the promotion from working as the Lead Neuro nurse for the hospital and comes with great knowledge and understanding of the program. Also, Dr. Brian Hard stepped up to be the Stroke Team Physician Leader. These changes bring on great opportunities for the Stroke program and we are really excited to see what benefits will be reaped from this.

Redmond is very proud to announce receiving the Gold Plus Achievement Award from the American Heart Association/American Stroke Association on September 6, 2011, which was presented by Mary Robichaux. This awards ceremony was a great celebration of accomplishment from the whole team. John Quinlivan (CEO) and Kay Rhodes (CNO) were proud to speak of this award and gave special congratulations to the whole team for providing excellent care to the patients and families we serve in our community.

RRMC also is active in community health fair events where educational material is provided to the community. In August we provided GA Power with Stroke Risk Assessment materials and also provided angioscreening onsite to their employees. We had a tremendous turnout to this and have other planned for the near future.

In September, RRMC held a Senior Care luncheon for the neighboring care facilities that provide continued care for our community in a long-term setting. This luncheon focused on Heart Failure and Stroke Awareness. We had a turnout of over 30 participants who received information about these 2 topics and took it back to their staff for even further emphasis on stroke awareness. Interest was expressed on meeting one-on-one with staff, and that is a plan for the future.

Pictured left to right: Laura Snow, RN (Neurology floor Director), Kay Rhodes, RN (Chief Nursing Officer), Misty Burkhalter, RN (Stroke Coordinator), John Quinlivan (Chief Executive Officer. NW Georgia Market President)

Thank you to Redmond Regional for contributing this article.

Georgia Stroke Professional Alliance

The next GA-SPA meeting is scheduled for Wednesday, November 30th from 10 – 3 at Emory University Hospital in the 2nd floor auditorium. Dr. Ralph Sacco will be the guest speaker. Dr. Sacco is Chairman of the Department of Neurology at the University of Miami and is a world-renowned neurologist who has lectured nationally and internationally on various topics related to stroke care. Dr. Sacco was the first neurologist to serve as president of the American Heart Association. Feel free to invite your key stroke personnel, stroke champions, and stroke medical directors. To register and for more information, contact Kerrie Krompf at 404-616-8741 or kkrompf@emory.edu

Coverdell Highlights

October Conference Call

Many thanks to Dr. Michael Frankel, the lead neurologist for the Georgia Coverdell Acute Stroke Registry, for presenting an update on "Door-to-Needle Time in Georgia". Dr. Frankel highlighted how the Georgia Coverdell hospitals have done with door-to-needle time since we rolled this out as our quality focus in January 2011. We will continue to have additional Coverdell conference calls devoted to this very important topic.

November Conference Call

Joanne Labelle, the clinical QI nurse for the Massachusetts Coverdell Stroke Registry, presented on the November call. Joanne shared with us many of the QI tools that were developed and are currently being used in Massachusetts. It was an interactive call and everyone was able to follow along on their computers. We would like to take this opportunity to thank Joanne for sharing many of her creative tools with all of us in Georgia.

Coverdell Q-TIP

Improving patient and family responses to the follow-up phone calls for patient satisfaction surveys can be challenging. Often the numbers are incorrect or have been disconnected or changed, and patients or family members may be reluctant to answer the call from the hospital if they are concerned that the call is about the hospital bill. To improve this situation, the Stroke Team at Atlanta Medical Center developed a few strategies that are improving responses from the patients and families:

- First, being sure that they are aware that a member of the stroke team will be calling them to allow them to share how their hospital experience was and that their discharge planning needs were met.
- Second, confirm that the phone number on record is correct and request at least one (preferably two) alternate numbers as to where to contact them.
- Third, and the one that seems to have really made a difference, is that the number the return calls are made from is listed as "Nurse Educator", not the name of your hospital. For patients who have caller ID, this will assure them that the hospital is not calling regarding a bill. This was done at Atlanta Medical Center through their telecommunications department and did not cost anything to implement.

There has been a significant improvement in the "No Answers" and there are fewer wrong numbers when the calls are made.

Thank you to Debbie Camp for submitting this informative Q-Tip!